Commonwealth of Massachusetts
Group Insurance Commission

Return completed form to the GIC Coordinator at your City/Town Benefits Office. Do not return to the GIC

Municipal Insurance Enrollment and Change Form (FORM -1MUN)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	666/

Name - Last	First	MI	Check one: ☐ Active Employee ☐ Retiree ☐ Survivor

Address	☐ This is a new address	City	State	Zip Code

Date Entered Service	City or Town employed or retired from	Home Phone	Work Phone
/ /		( )	( )

02 ☐ **HEALTH COVERAGE** — **Effective Date: / 01 /**

New Enrollment ☐ | Change ☐ | Cancel Coverage ☐ | Reinstatement after military leave ☐

NEW ENROLLMENTS – FOR AGENCY USE ONLY

☐ **Health** (Select one of the health plans below and individual or family coverage)

Does the employee participate in a public retirement system? ☐ Yes ☐ No

Number work hours/week _____

Health Plan – Active Employees and Non-Medicare Retirees/Survivors

- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (PPO)
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ NHP Care – Neighborhood Health Plan (HMO)
- ☐ Tufts Health Plan Navigator (PPO)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)

Coverage
- ☐ **Individual**
- ☐ **Family**

03 ☐ **Name Change**	Previous Name	New Name

INSURED CHANGES

FOR GIC USE ONLY: **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / / Medicare Eligible Attach copy of Medicare claim card (check if applicable) ☐ Insured ☐ Spouse Medicare Plan Name _____

07 ☐ **Transfer to another Agency /Municipality** Name of Agency/Municipality Transferred to Effective Date / /

08 ☐ **Transfer from another Agency/Municipality** Previous Agency/Municipality Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason

_____ Termination Date _____/_____/_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

School Department Employees Only: Termination date _____/_____/_____ Premiums paid through _____/_____/_____

SIGNATURE REQUIRED

Deduction Authorization
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.

At Retirement
I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Survivors
I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.

Termination
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision